APPEAL NO. 93425

At a contested case hearing held in (city, Texas, on April 28, 1993, the hearing officer, (hearing officer), determined that the respondent (claimant) reached maximum medical improvement (MMI) on January 11, 1993, with a 23% whole body impairment rating pursuant to the report of the designated doctor whose report was determined not to be contrary to the great weight of the other medical evidence. The hearing officer further determined that another doctor, whom the appellant (carrier) contended had been mutually agreed to by the parties to be the designated doctor, was not a designated doctor. In its request for review, the carrier, in effect, challenges the correctness of the MMI and impairment rating determinations by asserting that the hearing officer erred in finding that carrier did not follow the provisions of Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE §§ 130.6(a), (b), (c), and (d) (Rules 130.6(a), (b), (c), and (d)), that carrier was required to advise the claimant of the existence of an ombudsman, that the designated doctor was properly appointed by the Texas Workers' Compensation Commission (Commission), and erred in concluding that the other doctor was not a designated doctor. Claimant's response urges our affirmance.

DECISION

Finding the evidence sufficiently supporting the challenged findings and conclusions, we affirm.

Claimant testified she had worked for Levi Strauss (employer) for approximately 26 years when on (date of injury), the date of her undisputed compensable injury, she felt bad and saw employer's nurse. When the exercises and Tylenol she was given did not provide relief, she returned to the nurse and eventually was seen on December 17, 1991, by (Dr. H), her treating doctor. According to Dr. H's Report of Medical Evaluation (TWCC-69), which reflected a visit date of "8/18/92," claimant did repetitive work and had an injury "consistent with cervical discogenic syndrome, bilateral shoulder/hand syndromes." This TWCC-69 also indicated conservative treatment, completion of a work hardening program, and an ability to do light work with avoidance of repetitive type work activities. Dr. H certified that claimant reached MMI on "8/18/92" with a 26% whole body impairment rating for injuries to her cervical spine and upper extremities.

(Dr. B), whom the carrier contended was the mutually agreed upon designated doctor, stated in a TWCC-69 that claimant reached MMI on "8/18/92," with a 4% impairment rating. (Dr. A), the doctor selected by the Commission as the designated doctor, stated in his TWCC-69, dated January 14, 1993, that claimant reached MMI on "1/11/93," with a 23% impairment rating. The carrier's position at the hearing was that Dr. B was the designated doctor because the carrier and the claimant had mutually agreed upon him to be the designated doctor, and thus his 8/18/92 MMI date and 4% rating should be adopted by the Commission. Claimant's position was that she did not agree to Dr. B as the designated doctor. Rather, she was given his name and the names of two other doctors by the carrier, was told she had to see one of the three, and was given no choice in the matter. Thus,

when Dr. B assigned her an impairment rating of 4%, she obtained an attorney and undertook action to dispute Dr. B's rating and to request that the Commission select a designated doctor to resolve the dispute. The focus of the evidence and argument at the hearing was not upon the weight of the medical evidence vis-a-vis Dr. A's report, as such, but rather upon the issue whether claimant and carrier had mutually agreed upon Dr. B to be a designated doctor.

Though she could not recall the date, claimant acknowledged that sometime after Dr. H reported her as having reached MMI, apparently in September 1992, she was contacted about seeing another doctor by (Ms. N), the adjuster who handled her claim for carrier at that time. Carrier's computer printout in evidence (Comments Index) contained an entry for September 8, 1992, stating that claimant was called and advised that the carrier would start payment of impairment income benefits (IIBS) but disputed the impairment rating. This entry also stated that carrier had attempted to secure a designated doctor evaluation with Dr. B, Dr L., or Dr. C but that claimant said she would think about it and call back. The carrier introduced its letter to the Commission, dated September 9, 1992, advising that it disputed Dr. H's impairment rating but did not wish to enter a rating itself. The letter went on to state that carrier would attempt to secure a mutually agreed designated doctor but that if it did not inform the Commission thereof within the prescribed 10 days, the Commission was requested to appoint the designated doctor. The Comments Index also stated that on September 11th claimant called the carrier, agreed to see Dr. B for a designated doctor, and said she was leaving for Lubbock, Texas, due to a family death. Claimant agreed she had gone to Lubbock. Claimant said that Ms. N gave her the names of three doctors and told her that if she did not choose one of them, "we are going to send you to one of them anyway." She said she was given three days to provide an answer and was not told what a mutually agreed upon doctor meant nor did Ms. N tell her the meaning of or effect of selecting one of the three doctors. She said she called Ms. N back and was told she would be given the address of the doctor and the appointment information. She said she saw Dr. B because Ms. N told her if she did not go they would send her and that Ms. N gave her no choice.

Claimant introduced a September 22, 1992, letter from Ms. N to claimant which referred to their "agreement on 9-11-92" that claimant would be seen by Dr. B for a "second opinion" on October 12th. The carrier introduced a letter from Ms. N to claimant, dated September 29, 1992, which was identical to its September 22nd letter except that it contained an additional sentence stating that "you are advised that said evaluation will be final and binding." Claimant did not recall receiving this letter. The carrier also introduced a printout from the Commission entitled "Texas Compass" which contained an entry dated 10/08/92 stating: "Carrier and Clmt reached a mutual agreement on [Dr. B]." Claimant introduced her Notice of Dispute, dated October 26, 1992, disputing Dr. B's impairment rating; her letter of November 17, 1992, to the Commission stating that she would attempt to obtain a mutually agreed designated doctor, and requesting the Commission to appoint a designated doctor if not informed within 10 days (that a mutually agreed designated doctor was obtained); and the Commission's Request for Medical Examination Order (TWCC-22)

setting claimant's appointment with Dr. A for an examination the purpose of which was stated as: "Designated doctor requested to resolve dispute over: MMI and/or Impairment Rating."

Claimant, whose testimony at the hearing was given in Spanish and translated, acknowledged that Ms. N sent her the letter of September 22, 1992, and indicated that she can read some words that she knows, and that her husband or other persons assist her in reading English language documents. She said she did not go to or call the Commission until after she was seen by Dr. B, that she received no assistance from the Commission before seeing Dr. B, and that she had no recollection of any phone call from the Commission advising that Dr. B's decision would be "final and binding." Claimant also testified that neither Ms. N nor any person from the Commission ever advised her that a Commission ombudsman could explain to her the content of an agreement on a designated doctor. She said that after she received Dr. B's evaluation, with which she disagreed, she called the Commission and was told that if she disagreed with Dr. B's rating she could appeal to another doctor and that she would be sent some papers.

The carrier called MM, an adjuster, who testified that she inherited the file after the Benefit Review Conference and that Ms. N was the former adjuster for claimant's claim but was no longer in the carrier's employ. She could only speculate and had no personal knowledge as to why Ms. N sent claimant both the September 22nd and September 29th letters and why the additional paragraph concerning "final and binding" was included in the second letter. This witness also stated she could not point to any entry on the carrier's Comments Index indicating that the carrier objected to the Commission's appointing Dr. A as the designated doctor though she also said that the Comments Index contained only a portion of carrier's file comments.

At the hearing the claimant requested that the hearing officer take official notice of the Commission's claim file in this case and of the documents (apparently referring to documents in evidence) which were not in that file. There was no objection and the hearing officer agreed to do so. In the Decision and Order, the hearing officer stated that the carrier's letter of September 9, 1992, was in the claims file, but that carrier's September 22nd letter and its Comments Index were not. With respect to the content of the Commission's file, the hearing officer also stated: "Contained in the claims file is a Dispute Resolution Form dated 12/4/92 signed by Monica Martinez with a notation that [Dr. B] is an RME doctor. There is no indication in the claims file of [Dr. B] being any type of designated doctor, agreed to or otherwise. There is no indication in the hard file or the computer file of a call received from Carrier on September 21, 1992." The reference to the absence of any record of a call on September 21st apparently had reference to the following entry of that date in Carrier's Comments Index: "Called TWCC / advise mutually agreed desig Dr eval set up LMCB." There being no objection at the hearing to the hearing officer's considering documents in the claim file as well as the absence of documents and information therein,

and there being no appealed issue concerning same, we need to not further discuss it. However, we repeat our discussion of the procedure recommended concerning the use of claims files. In Texas Workers' Compensation Commission Appeal No. 93103, decided March 22, 1993, we stated the following respecting official notice of claims files:

Hearing officers should not take official notice of entire claim files. We recommend that the hearing officer make hearing officer exhibits of relevant documents which are in the claim file and which the hearing officer wishes to consider in resolving the case, instead of taking official notice of such documents. In this way, the parties and the Appeals Panel can more readily discern which documents were considered by the hearing officer and such documents are more likely to be transmitted to the Appeals Panel when a case is appealed (without an additional request for the documents) than if the documents are officially noticed.

The factual findings and legal conclusions pertinent to the resolution of this case are set forth below.

FINDINGS OF FACT

4. CLAIMANT'S treating doctor, Dr. [H], certified that CLAIMANT reached maximum medical improvement on August 18, 1992, with a 26% whole body impairment rating.

5. CARRIER disputed the impairment rating assigned by Dr. [H] and attempted to reach an agreement with CLAIMANT on a designated doctor.

6. The provisions of 28 TAC § 130.6 (a), (b), (c), and (d) were not followed by CARRIER in attempting to reach an agreement with CLAIMANT.

7. CLAIMANT was seen by Dr. [B] on October 12, 1992, and he certified that CLAIMANT reached maximum medical improvement on August 18, 1992, with a 4% whole body impairment rating.

8. On November 17, 1992, CLAIMANT disputed the maximum medical improvement date and impairment rating assigned by Dr. [B].

9. On December 4, 1992, Dr. [A] was appointed by the commission to act as designated doctor.

10.Dr. [A] determined that CLAIMANT reached maximum medical improvement on January 11, 1993, with a 23% whole body impairment rating.

CONCLUSIONS OF LAW

2.CLAIMANT reached maximum medical improvement on January 11, 1993, with a 23% whole body impairment rating.

3.Dr. [B] was not a designated doctor.

4.Dr. [A] was the designated doctor and his report was not contrary to the great weight of the other medical evidence.

The carrier, contending the parties mutually agreed that Dr. B was to be the designated doctor and that his impairment rating should be adopted, specifically challenges Finding of Fact No. 6, disputes Finding of Fact No. 9 because of carrier's contention that Dr. A was not properly appointed as a designated doctor, and challenges Conclusion of Law No. 3. The carrier also asserts on appeal that it was not required to advise claimant of the Commission's Ombudsman Program. This challenge apparently relates to the statement in the hearing officer's summary of the evidence that no person with either the Commission or the carrier ever told claimant of the availability of a Commission ombudsman to explain the content of an agreement to a designated doctor. Since there was no factual finding or legal conclusion made on this matter, however, and since the statement accurately reflected claimant's testimony, we find no merit in carrier's assertion.

It is not disputed that claimant's treating doctor, Dr. H, certified that claimant reached MMI on August 18, 1992, with an impairment rating of 26%, and that the carrier desired to dispute such rating. At that point, the mechanism for the resolution of disputes over MMI and impairment ratings, namely, having claimant examined by a designated doctor either agreed upon by the parties or selected by the Commission, would be appropriately invoked by the carrier and that may be what the carrier intended to do. However, given the unrefuted evidence that the carrier gave claimant the names of three doctors, told her she had to select one of the three, and that if she failed to do so she would be sent to one of the three anyway, the carrier may have decided to have the claimant examined by its own choice of doctor pursuant to the required medical examination procedures (RME exam) set forth in Article 8308-4.16 (Required Medical Examinations), Rule 126.5 (Procedure for Requesting Required Medical Examinations), and Rule 126.6 (Order for Required Medical Examinations).

In Texas Workers' Compensation Commission Appeal No. 92312, decided August 19, 1992, where we affirmed the hearing officer's determination that the parties had agreed to a designated doctor, we noted that "the mechanism for resolving conflicts in issues over MMI or impairment is resort to an independent `designated' doctor. *See* Articles 8308-4.25,

4.26, 8.05." The following observations in Texas Workers' Compensation Commission Appeal No. 92511, decided November 12, 1992, bear repeating here: ". . . use of a designated doctor is clearly intended under the Act to assign an impartial doctor to resolve disputes over MMI and impairment rating. To achieve this end, his/her report is given at least presumptive weight, and possibly conclusive weight, on the issue of impairment rating, this distinction depending upon whether he/she is appointed by the Commission or selected through agreement of the parties. Art. 8308-4.26(g). The status of a doctor as `designated,' as opposed to a medical examination order doctor appointed under Art. 8308-4.16, or a carrier-recommended treating doctor, should be established prior to the date the examination is conducted." As for obtaining the agreement of claimant for an RME exam, both Article 8308-4.16(b) and Rule 126.5 envisage that a carrier shall first attempt to obtain the employee's permission and concurrence for the examination before the Commission requires such examination by its order. Respecting agreement on a designated doctor, Articles 8308-4.25(b) and 8308-4.26(g) provide that the Commission will direct the employee to be examined by a designated doctor selected by the mutual agreement of the parties, and that if the parties cannot agree on a designated doctor the Commission will select one. *And see* Rule 130.5 (Impairment Rating Disputes) and Rule 130.6 (Designated Doctor: General Provisions). Rule 130.5(d) provides that if the carrier elects not to perform its own reasonable impairment rating assessment, as was the case here, then it may file a request for selection of a designated doctor, and that Rule 130.6 will apply with certain exceptions.

While it may well be that the carrier intended to and believed it was pursuing its impairment rating dispute by invoking the designated doctor procedures, and that it had obtained claimant's agreement to be examined by Dr. B in that capacity, the evidence supports the determination that claimant did not agree to see Dr. B as a designated doctor and that Dr. A was, therefore, properly appointed by the Commission as the designated doctor. Claimant's unrefuted testimony was that the carrier gave her three doctors' names, told her to select one to examine her, and gave her no choice in the matter of being examined by one of the three. Such circumstances can hardly be said to be tantamount to a mutual agreement on a designated doctor. There was also evidence that the Commission as well did not regard Dr. B as a designated doctor, not the least of which was its appointment of Dr. A. We are satisfied that the evidence supports the hearing officer's determinations that while the carrier attempted to reach an agreement with claimant on a designated doctor, Dr. B was not a designated doctor, that Dr. A was appointed by the Commission as the designated doctor, and that his report was not contrary to the great weight of the other medical evidence.

The carrier's challenge to Finding of Fact No. 6 concerning the carrier's failure to follow the provisions of Rule 130.6(a) through (d) is problematical though not fatally so. Those provisions are set forth below.

Rule 130.6: Designated Doctor: General Provisions

(a)If the commission receives a notice from the employee or the insurance carrier that disputes either [MMI] or an assigned impairment rating, the commission shall notify the employee and the insurance carrier that a designated doctor will be directed to examine the employee.

(b)After notifying the employee and the insurance carrier, the commission shall allow the employee and insurance carrier ten days to agree on a designated doctor. The commission shall inform an unrepresented employee that an OMBUDSMAN is available to explain the contents of the agreement for a designated doctor.

(c)If the employee and the insurance carrier agree on a designated doctor, the carrier shall, within ten days, send a confirmation letter to the employee, with a copy to the commission. The letter shall include:

(1)the workers' compensation number assigned to the claim by the commission;

(2)the employee's name, address, and social security number;

(3)the date of the injury; and

(4)the designated doctor's name, business address, and telephone number, and the time and date of the examination.

(d)The commission shall contact the worker to confirm the agreement. If the commission is not notified by the end of the tenth day that an agreement has been reached, the commission shall issue an order directing the employee to be examined by a designated doctor chosen by the commission. The examination shall be held within a reasonable time after the order is made. The order shall specify the name, business address, and telephone number of the designated doctor, and the date and time of the examination.

Rules 130.6(a), (b), and (d) do not appear to place any requirement on the carrier as such and we are at a loss to understand the hearing officer's finding that the carrier failed to follow those provisions in attempting to reach an agreement with the claimant. As for Rule 130.6(c), the carrier, believing it had an agreement with claimant to be examined by Dr. B as a designated doctor, did send a confirmatory letter dated September 22nd which claimant did not deny having received. That letter appeared to have been sent within 10 days of the alleged agreement since, as reflected on the carrier's Comments Index, claimant called the carrier on September 11th agreeing to see Dr. B. and also indicating she was leaving for Lubbock.

The hearing officer did not explain how she arrived at Finding of Fact No. 6 in her decision and we find it unsupported in the evidence. However, we further find it unnecessary to support the conclusions of law and the decision and we disregard it. Texas Workers' Compensation Commission Appeal No. 92145, decided May 27, 1992. This case turned, not on the compliance by the Commission or the carrier with the provisions of Rule 130.6, but rather on whether the carrier met its burden of showing, as it contended, that the claimant agreed on Dr. B to be the designated doctor. We are satisfied that the remaining factual findings as well as the legal conclusions are sufficiently supported by the evidence. *Compare* Texas Workers' Compensation Commission Appeal No. 92244, decided July 24, 1992; Texas Workers' Compensation Commission Appeal No. 93170, decided April 22, 1993.

The hearing officer is the sole judge of the weight and credibility of the evidence. Article 8308-6.34(3). We do not substitute our judgement for that of the hearing officer where, as here, the challenged findings are supported by sufficient evidence. Texas Employers Insurance Association v. Alcantara, 764 S.W.2d 865 (Tex. App.-Texarkana 1989, no writ). The challenged findings and conclusions of the hearing officer are not so against the great weight and preponderance of the evidence as to be manifestly unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Pool v. Ford Motor Co., 751 S.W.2d 629 (Tex. 1986).

Finding the evidence sufficient to support the hearing officer's decision, we affirm.

Philip F. O'Neill
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Lynda H. Nesenholtz

Appeals Judge